Schmieding /ILC Solutions Forum on Elder Caregiving

June 2, 2005 ♦ 9 am -12 noon

Schmieding Conference on Elder Homecare

June 2, 2005 ♦ 12 noon - 4 pm

REPORT OF FINDING

CATHEY S. POWERS, MD, CHIEF, HOME HEALTH CARE SERVICE, CAVHS

NEW DEFINITIONS OF HOME: PARTNERING ADULT FOSTER CARE WITH MEDICAL CARE

TYPE TOPIC OF PRESENTATION

SOLUTIONS FOR KEEPING ELDERS AT HOME FOR LIFE

TESTIMONY OF CATHEY S. POWERS, MD TO THE POLICY COMMITTEE OF THE WHITE HOUSE CONFERENCE ON AGING

I am the Chief of the Home Health Care Service for CAVHS and the Medical Director for Home Based Primary Care (HBPC) at the Central Arkansas Veterans' Healthcare System (CAVHS). I am a fellowship- trained geriatrician with an Internal Medicine background and have been with CAVHS Home Care since 1990. This morning I would like to summarize the successful experience of HBPC in establishing Medical Foster Homes for veterans in central Arkansas.

SUMMARY OF FINDINGS

Approximately 6% of the US population aged 65 and greater reside in nursing homes with twenty percent of elders aged 85 or older residing in nursing homes. Individuals living in the US currently face a 1 in 2 lifetime chance of nursing home admission which has many worrying that the need will soon outpace the need for long term care. It is also recognized that for every elder residing in a nursing home, there are three to four equally disabled residing in the community. The overwhelming majority of these elders want to avoid nursing home placement even if their physical and social situation does not support a decision to remain at home. These individuals are at risk not only for medical and functional problems but they are also at greatly increased risk for depression and social isolation. Home Based Primary Care (HBPC) is an established VA program that typically uses an interdisciplinary health care team to deliver primary care to chronically ill homebound veterans, the majority of whom are elderly. This team typically follows patients until death and thus also is invested in providing end-of-life care in the home. We may follow patients for 20 years or more during which time the patient may have lost caregivers and stable social situations that would preclude us from continuing to care for them and would generally necessitate the patient being placed in a nursing home. Because of many of patients having expressed wishes against nursing home placement, the Home Based Primary Care (HBPC) program at Central Arkansas Veterans Healthcare Systems (CAVHS) began many years ago assisting a small number of patients to relocate to private homes when they could no longer live independently. These patients did not meet the criteria for Community Residential Care because they were not capable of self-preservation. The private homes we found for these veterans were not required to meet Arkansas residential care regulations since they had 3 or fewer clients. And because this was a non-institutional setting, HBPC was still able to provide health care to the veteran. This also allowed monitoring of the placement and consistent verification that appropriate day-to-day care was being delivered.

In 1999, HBPC learned of VHA's New Clinical Initiatives Program and submitted a proposal that partnered adult foster care with HBPC medical care for complex chronically ill veterans giving us the opportunity to formalize the process we had previously done on a small scale. The proposal was approved for funding for FY 2000 and 2001. Early in the project, the medical center funded a visit to Oregon for the Medical Foster Home Coordinator formerly an HBPC social worker who had been involved in arranging the informal placements. This visit was highly beneficial since Oregon has a program of adult foster care that can compare to its institutional population and has a long

track record and well-established processes. Oregon also does not disqualify individuals on the basis of any particular condition, medical or behavioral. The residents in Oregon's adult foster care program, however, receive only usual and customary health care. We believed that the integration of medical care and adult foster care would permit excellent oversight and added stability and support for both the veteran and the foster caregivers.

Here is how the program works:

The foster care coordinator recruits caring families and individuals in the HBPC catchment area that in our state takes in parts of twelve counties. The program is designed so as to maintain a family like atmosphere where no more than 3 residents will be placed. Often times, the caregivers have previously been in the health professions or done personal care and are now retired and wish to remain at home but active. The coordinator assesses the prospective caregivers for their ability and motivation. He then obtains criminal background checks on all individuals who will be residing on the premises, whether they work with the veterans or not, and checks references. If the caregivers are approved, one of the VA safety engineers then does a safety inspection of the home. Any recommendations must be addressed before a veteran can be placed in the home. The HBPC interdisciplinary team also assesses the ability of the family to provide routine care, prepare proper diets, etc. The coordinator then begins to match residents and caregivers e.g. those veterans with pets matched to families that will allow pets to accompany the resident. The coordinator serves as an intermediary between the veteran and the foster caregivers. He involves veterans, and where applicable, veterans' family members by having them visit the recruited homes that would seem to be a match. He also works with the caregivers and veteran to set the monthly fee based on the degree of care the veteran needs. This ranges from approximately $1800-$2400 a month. The veterans themselves pay for the foster care using their Social Security, private or VA pensions, or service – connected disability compensation. For this fee, the veterans receive a private room, personal care, 24-hour supervision, meals, laundry and activities. This is considered to be the veteran's home with the view that they will continue to age in place and remain in the home even when they become terminal. The VA, through HBPC, provides medications, supplies, and health care. HBPC personnel make both scheduled and unscheduled visits which assists us in safeguarding against any abuse.

This pilot was so successful that our medical center elected to cover the cost of the program when the Clinical Initiative funding ended. Approximately one-third of the HBPC patient caseload currently consists of patients in Medical Foster Care. The office of Geriatrics and Extended Care in VACO has also endorsed the program. Since our pilot project was completed, the Tampa VA has developed a Medical Foster Home Program and a national VA training session is planned for mid-June at our facility so that the program can be developed throughout the nation. The benefits to this program include:

- Provision of a safe and therapeutic environment
- An alternative to institutionalization
- Allowing individuals to "age in place" and even provide non-institutional terminal care
- Offering personalized and customary care in the individual's community

- Improving the quality of life by partnering health care and residential care, providing socialization, and oftentimes providing family to the veteran for the first time in many years

- Reducing VHA costs when veterans otherwise must be placed in nursing homes at VHA expense

RECOMMENDATIONS AND REFORMS

I believe the first recommendation would be to think about long term care as a spectrum of services with less emphasis on nursing homes. The adult foster care system in Oregon is said to have almost 50% of the number of beds of nursing homes at two-thirds of the cost of nursing homes. Medicaid waivers for this type of program should be considered the norm rather than the exception.

The second recommendation would be to partner health care to this endeavor. This would strengthen the program and catch deficiencies and problems before such resulted in harm. In visiting Oregon, our coordinator shared our program plans for doing just that and was universally met with envy on the part of state workers for this type of support in the adult foster home system. In the Oregon system, adult foster caregivers would likely have as many physicians and health providers to deal with as they had patients resulting in multiple health related visits and a lack of care coordination. The states could enter into agreements for developing this healthcare partnership as they develop foster care programs as an alternative long-term care setting.

We know that complex and frail elders can be given a quality of life far exceeding what many have in a great number of institutional settings. Adult foster care is not without its pitfalls, too, but there are demonstrated means to minimize them. The work in adult foster care is very hard but also very rewarding. I believe that developing these types of programs honor the heritage of those who have made this country the success that it is and creates a brighter future for us all.